Confirmatory Exam for Congenital Abnormality by Specialist

If more than one baby fill a separate sheet for each baby (A, B, C for each child born - in order of birth)

Mother's Hospital ID: _____ **Mother's Registry ID Code:** _____

Mother's Initials: _____ **Mother's DOB/Age:** _____

Baby's Hospital ID: _____ **Baby's Registry ID Code:** _____

Place of Delivery: _____ **Place of Initial Assessment:** _____

DOB of infant: _____ **Date of Examination:** _____

Assessment of the new born (or stillborn baby) (Take photo if abnormalities detected)

Weight (g) _____ **Supine length (cm)** _____ **Head Circumference (cm)** _____

Heart rate (per minute): _____ **Respiratory rate (per minute):** _____

Reason for Referral of Child for Examination:

Pertinent History:

Examination Findings:	If Abnormal, Please describe:

Summary of examination findings:

Recommendations:

Clinician's Details:

Name of examining doctor: _____ **Qualification:** _____

Are you aware of the medicines taken by the mother during pregnancy?

Yes	No	Not Sure

Facility Name: _____

Telephone: _____ **Email:** _____ **Fax:** _____

Signature _____ **Date of report:** _____

Photograph of congenital anomaly provided?	Yes	No	

* Attach photograph to form -record ID code and clinic name with the photo